Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2128HOS	A. BUILDING _____ B. WING _____	08/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT WILLOW TREATMENT CENTER	6171 W CHARLESTON BLVD, BLDG #17 LAS VEGAS, NV 89146

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S 000	Initial Comments Surveyor: 26855 This Statement of Deficiencies was generated as a result of a State licensure focused survey and complaint investigation conducted in your facility on 08/24/09 and finalized on 08/27/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00022688 was substantiated with deficiencies cited. (See Tags S0320,S0325,S0328,S0329) Complaint #NV00022683 was substantiated with deficiencies cited. (See Tag S0320) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified	S 000		
S 060 SS=F	NAC 449.3152 Quality Improvement	S 060		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 060	Continued From page 1 1. The governing body of a hospital shall ensure that the hospital has an effective, comprehensive quality improvement program to evaluate the provision of care to its patients. This Regulation is not met as evidenced by: Surveyor: 21994 Based on interview, document review and chart review the facility failed to ensure there was an effective, comprehensive quality improvement program to evaluate the provisions of care for its patients as follows: 1. The facility did not indicate, track, trend, introduce preventive strategies or provide innovated alternatives to improve the process of using of chemical restraints. 2. Patient injuries during Conflict Prevention and Response Training (CPART) Holds/Seclusion were not tracked nor trended. 3. The facility was not able to provide readily retrievable records of all denials of patient's rights in accordance with the facility's Patient's Rights Policy #2.01 originally effective 1/1/2005 with a revision date of 12/07 Section III, M. 4. The facility did not have a an effective way to evaluate their incident investigation process to ensure the safety and protection of their patients. 6. The facility had no documented evidence of a plan to reduce the number of chemical and physical restraints. Severity: 2 Scope: 3	S 060		
S 216 SS=D	NAC 449.340 Pharmaceutical Services	S 216		

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S 216	Continued From page 2 2. The pharmacy and area for drug storage must be administered in accordance with all applicable state and federal laws. This Regulation is not met as evidenced by: Surveyor: 26855 Based on observation, interview and policy and procedure review the facility failed to ensure psychotropic medication was kept secured in a locked storage area in accordance with applicable state and federal laws. Severity: 2 Scope: 1	S 216		
S 297 SS=F	NAC 449.361 Nursing Service 8. The chief administrative nurse shall define the policies, procedures and standards relating to the provision of nursing services and shall ensure that the members of the nursing staff carry out those policies, procedures and standards. The policies, procedures and standards must be documented and accessible to each member of the nursing staff in written or electronic form. The chief administrative nurse must approve each element of the policies, procedures and standards before the element may be used or put into effect. This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and document review the chief administrative nurse failed to ensure members of the nursing staff consistently followed the facilities restraint and suicide prevention policies and procedures for 9 of 11 patients. (Patients #1, #2, #3, #4, #5, #6, #7, #8, and #9)	S 297		

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S 297	Continued From page 3 1. Nursing staff failed to consistently obtain physicians' orders for all instances of physical and chemical restraint use. 2. Nursing staff failed to document all instances of physical and chemical restraint use on the facility's "Restraint Incident Report" form. 3. Nursing staff failed to consistently complete a "Denial of Rights for Persons with Mental Illness" for all instances when patients were placed in physical restraints and when chemical restraints were used. 4. Nursing staff failed to consistently complete a "Restraint and Seclusion Debriefing and Positive Behavior Intervention Plan" for all instances of physical and chemical restraint use. 5. Nursing staff failed to document the consistently "Reasons and Results" for all IM PRN (intramuscular as needed) medications. 6. Nursing staff failed to consistently ensure a physical assessment was completed and documented for each occurrence of physical restraint. 7. Nursing staff failed to consistently contact the parents or legal guardians when suicide precautions were initiated per the facilities Suicide Prevention policy. Severity: 2 Scope: 3	S 297		
S 298 SS=D	NAC 449.361 Nursing Service 9. A hospital shall ensure that its patients receive proper treatment and care provided by its nursing services in accordance with nationally recognized	S 298		

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S 298	Continued From page 4 standards of practice and physicians' orders. This Regulation is not met as evidenced by: Surveyor: 27469 Based on record review, the facility failed to ensure the nursing staff had the knowledge to operate an aerosol machine for 1 of 11 patients. (Patient #9) Severity: 2 Scope: 1	S 298		
S 318 SS=F	NAC 449.3626 Rights of Patient A governing body shall develop and carry out policies and procedures that protect and support the rights of patients as set forth in NRS 449.700 to 449.730, inclusive. This Regulation is not met as evidenced by: Surveyor: 21994 Based on interview, document review, and record review the governing body failed to develop policies regarding chemical restraints that were in compliance with NRS 433.5503 and failed ensure the facility protected the rights of patients in accordance with facility policies pertinent to patient rights (Reporting of Denial of Rights and Restraint//Seclusion of Patients) for 9 of 11 patients (Patients #1, #2, #3, #4, #5, #6, #7, #8, and #9) as follows: 1. The facility failed to consistently follow policies pertinent to Patient Rights (i.e. Reporting of Denial of Rights; Patient Rights; Restraint/Seclusion of Patients). 2. The facility's policies regarding chemical	S 318		

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S 318	Continued From page 5 restraints were not in compliance with NRS 433.5503. 3. The facility did not complete Denial of Rights (DOR) for chemical restraints. 4. The completion of a DOR was inconsistent for physical restraint and seclusion. 5. The completion of the DOR forms failed to contain all the required information. 6. The facility failed to ensure DOR forms were completed when patients on suicide prevention could not wear their own clothing. 7. The facility failed to ensure DOR forms were completed when patients on suicide prevention had their mattresses placed on the floor of the hall. 8. The facility did not conduct thorough investigations after incidents to ensure patients were protected and free of abuse and/or neglect. Severity: 2 Scope: 3	S 318		
S 320 SS=G	NAC 449.3628 Protection of Patient 1. A governing body shall develop and carry out policies and procedures that prevent and prohibit: (a) Verbal, sexual, physical and mental abuse of patients This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and document review the facility failed to carry out policies and procedures that prevented and prohibited the	S 320		

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S 320	Continued From page 6 physical abuse for 3 of 11 patients (Patients #1, #8, and #9). Findings include: Patient #1 Patient #1 was a 13 year old white juvenile admitted to the facility on 2/3/09 with diagnoses that included bipolar disorder, oppositional defiant disorder and impulse control disorder. The patient was discharged from the facility on 7/23/09. Patient #1 reported on 6/15/09, that he was physically abused by Employees #7 and #8 who twisted the patient's arm behind his back and pushed the patient up against a wall in the facility gym. The patient complained of pain in his arm as a result of the action by the two employees of the facility. Residential Treatment Center Services Continued Stay Request Note dated 6/18/09 indicated the patient was restrained on 6/15/09 for physical aggression towards a peer. The assessment was completed by Employee #6. On 8/25/09 at 10:20 AM, an interview was conducted with Employee #6 who reported Patient #1 complained on 6/15/09, that he was grabbed by Employee #7 and Employee #8 who twisted his arm behind his back and pushed him up against a wall in the facility gym. Employee #6 reported the patient was very upset when he spoke about the incident and complained that his arm hurt. He asked both employees to stop restraining him, but it felt like a long time passed before both employees released the restraint hold. Employee #6 reported the patient complained of pain in his shoulder and an x-ray	S 320		

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S 320	Continued From page 7	S 320		

was completed to rule out an injury. Employee #6 reported that she believed the incident occurred and assisted the patient in filling out a complaint about the incident which was submitted to Employee #2.

An incident report by Quality Assurance dated 7/30/09 indicated Patient #1 made an allegation of physical abuse from two staff members that was reported to Child Protective Services (CPS). An internal investigation was being conducted by Employee #2.

On 8/25/09 at 1:20 PM, an interview was conducted with Employee #2. Employee #2 reported she spoke with Employee #8 after receiving a complaint about Patient #1 being physically restrained by Employee #7 and Employee #8. Employee #2 reported she told Employee #8 she was processing a complaint about the incident where Patient #1 was held against the wall with his arm behind his back in the facility gym. Employee #8 confirmed the incident had occurred in the gym and told Employee #2 the patient was trying to run out of the gym and she had to stop him from leaving the gym. Employee #2 reported, after requesting and receiving a written statement about the incident from Employee #8, she was shocked that Employee #8's written statement was different from the verbal statement given to her earlier. Employee #2 reported Employee #8's written statement made no mention of physically restraining the patient with his arm behind his back. The statement indicated the patient was redirected and accompanied to a matted area where he was given teaching interaction and verbal reassurance until he was calm.

Employee #2 reported she conducted an

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S 320	Continued From page 8 investigation of the incident and obtained statements from Employee #6, Employee #7, Employee #8, and Employee #9 and felt the incident involving a physical restraint did occur. Employee #2 acknowledged the facilities abuse policy and procedure was not followed. Employee #2 reported the suspected abuse was not reported to law enforcement and no witnesses to the alleged physical abuse were interviewed because the facility's Clinical Program Manager thought interviewing patients would be disruptive to the milieu. Employee #2 acknowledged neither employee involved in the suspected abuse of the patient was placed on administrative leave following the incident and the patient was never transferred to another program to ensure the patient's proper care and protection. On 8/24/09 at 12:00 PM, an interview was conducted with Employee #8. Employee #8 denied any Conflict Prevention and Response Training (CPART) restraint holds were applied to Patient #1 in the gym on 6/15/09. Employee #8 indicated she and Employee #7 were observing 12 patients in the gym area when she observed Patient #1 yelling at a peer in the gym and asked him to take a time out. Patient #1 started yanking at the railing and at one point started walking towards the door of the gym in an attempt to leave. Patient #1 was verbally redirected to a matted area of the gym. Employee #8 reported the patient complied with verbal directions and at no time were any CPART restraint holds placed on the patient. Employee #8 reported she never physically touched the patient during the redirection. Employee #8 indicated she reported the patient's behavior to the charge nurse once the patients were returned to the unit. Employee #8 reported she had completed a CPART course	S 320		

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S 320	Continued From page 9 as part of her facility training and grabbing a patient's arm and twisting it behind his back while restraining the patient against a wall would not be an authorized or approved CPART restraint. A typed incident report from Employee #8 dated 8/1/09 documented an incident on 6/15/09 where Patient #1 displayed verbal aggression toward a certain male peer in the facility gym. Staff intervened and asked Patient #1 to take a time out by asking him to sit on the bleachers. Patient #1 walked over to the bleachers and started yanking at the railing and kicking the bleachers and attempted to walk out of the gym. Staff redirected the patient to a matted wall area where he was given teaching interaction and verbal assurance until he was calm. Patient #1 then returned to the bleachers where he sat until the gym time expired. Patients and staff members then returned to the unit. The incident was reported to Employee #9. A Communication Log entry dated 6/15/09 indicated Patient #1 had verbal and physical aggression telling a male peer to, "shut the (F) up" and refusing to follow instructions, kicking bleachers, yanking railing around on bleachers, yelling at staff." (There was no documentation of a CPART or physical restraint use on the patient.) On 8/25/09 at 1:00 PM, Employee #9 was interviewed regarding the alleged restraint of Patient #1 on 6/15/09 in the facility gym by Employee #7 and Employee #8. Employee #9 reported she was informed about the patient's verbal and physical aggression in the gym by both employees, but was not informed either employee ever restrained the patient. Employee #9 indicated the patient did not complain of shoulder pain when he returned to the unit on	S 320		

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S 320	Continued From page 10 6/15/09 and was not medicated for pain. Employee #9 reported the patient complained of shoulder pain a week later and the physician was called and an x-ray order was obtained for the patient's right shoulder. Employee #9 indicated she was distracted and forgot to write the order for the x-ray in the patients chart. Employee #9 reported, when she questioned Patient #1 about his shoulder pain and injury, he told her that Employee #7 and Employee #8 tried to stop him from leaving the gym on 6/15/09 and grabbed him and held him by his shoulders. A Nursing Progress Note dated 6/15/09 at 8:21 PM, by Employee #9 indicated Patient #1 took part in all unit activities with a flat affect and labile mood. "Attended, participated during fitness group, and played volleyball at the gym. He had a good appetite for dinner and snack. He had a positive phone call from mom. Took evening medication with no adverse reaction noted. Staff will continue to monitor for patient safety and comfort. Had VA (verbal aggression) PA (physical aggression) telling certain male peer to "shut the f up". Refused to comply with staff 's instructions, dramatic, negative attention seeking behavior, kicking bleachers, yanking railing, around on bleachers, yelling at staff, teaching interaction done with fair acceptance to feedback." A typed statement of the incident dated 8/2/09 from Employee #9 documented no takedown on Patient #1 was reported by Employee #7 or Employee #8. "The patient was just escorted against the wall and given teaching interaction to help calm him down. The patient reported he was taken down a week after the incident. I did not believe him because all the while he was playing volleyball without complaining of any pain. When it was time for fitness group he complained of	S 320		

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S 320	Continued From page 11 shoulder pain only before fitness group. Thus x-ray was done to validate his complaint which came out negative." On 8/25/09 at 3:00 PM, an interview was conducted with Employee #7 who denied any CPART holds were applied to Patient #1 on 6/15/09 in the gym area of the facility. Employee #7 reported the patient was exhibiting verbal and physical aggression and was yelling at a peer and kicking the bleachers and pulling on the railing in the gym. The patient attempted to leave the gym area and she blocked his path while Employee #8 positioned herself on the opposite side of the patient. The patient was verbally directed to a padded area of the gym. Employee #7 reported at no time did she or Employee #8 place the patient in a CPART hold or physically place their hands on the patient. Employee #7 indicated she had completed a CPART course as part of her facility training and twisting a patients arm behind his back and restraining the patient against a wall would not be an approved or authorized CPART hold. A typed incident report dated 8/14/09, by Employee #7 documented Patient #1 was playing volleyball with his peers and got angry at a fellow peer and yelled, "shut the f up. "Employee #7 and Employee #8 intervened and asked the patient to take a time out asking him to sit on the bleachers. "The patient stomped over to the bleachers and started yanking at the railing and kicking the bleachers. The patient attempted to walk out of the gym. Employee #7 stood in front of the gym door. Both employees then redirected and accompanied the patient to the matted area away from the door. Teaching interactions were were given to the patient to calm down and take deep breaths. The above behavior was reported	S 320		

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S 320	Continued From page 12 to the R.N." On 8/26/09 at 11:35 AM, an interview was conducted with Patient #4. Permission to interview the patient was obtained from the patient's father prior to the interview. Employee #6, the patients therapist was present during the interview. Patient #4 reported he remembered the incident on 6/15/09 that took place in the gym area of the facility. Patient #4 reported the incident occurred at 7:00 PM while the patients were playing volley ball. Patient #4 reported Patient #1 became agitated and angry and verbally yelled at him to "Shut the (F) up." Patient #4 reported at one point Patient #1 attempted to run out of the gym and was physically restrained by both Employee #7 and Employee #8. Patient #4 reported both employees grabbed Patient #1 by the shoulders and twisted his arm behind his back and pushed him up against a wall in the gym. Patient #4 estimated both employees restrained Patient #1 against the wall for approximately 15 seconds before having him sit on the bleachers. On 8/26/09 at 11:45 AM, an interview was conducted with Patient #2. Permission to interview the patient was obtained from the patient's mother prior to the interview. Employee #6, the patient's therapist, was present during the interview. Patient #2 reported he remembered the incident on 6/15/09, that took place in the facility gym. Patient #2 reported the incident took place in the evening between 7:15 PM and 8:00 PM while the patients were playing volleyball. Patient #2 reported Patient #1 became involved in a verbal argument with another patient and yelled, "Shut the (F) up." Patient #2 indicated Patient #1 was angry and agitated and at one point ran for the door of the gym. Patient #2	S 320		

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S 320	Continued From page 13 reported Employee #7 and Employee #8 both grabbed Patient #1, put his arm behind his back, and slammed him up against a wall in the gym. Patient #2 indicated Patient #1 was restrained by both employees against the wall for approximately 4 to 5 minutes. The facility June 2009 and July 2009 Restraint/Seclusion Log indicated there were no documented incidents of physical restraint or seclusion for Patient #1 on 06/15/09 or for the months of March 2009, April 2009, May 2009, June 2009, and July 2009. A review of Physicians Orders for Patient #1 failed to reveal evidence of a physician order for physical restraints on 6/15/09, the date of the alleged incident. A Communication Log entry dated 6/21/09 indicated an x-ray on the patient's right shoulder was completed. The x-ray was negative for fracture or dislocation. The facilities Restraint Seclusion Policy last revised 07/06 indicated restraint and seclusion shall only be used in an emergency safety measure in situations of imminent danger to patients, staff or others when less restrictive measures have been or likely to be ineffective in averting danger. Steps outlined in the procedure for restraint and seclusion included the following: 1. "Physician written or verbal orders for initial and continued use of restraints are required and and are time limited and are not written as PRN orders."	S 320		

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S 320	Continued From page 14 2. "The nurse will conduct a face to face assessment of the patients status immediately following restraint or seclusion." 3. "Designated parents/guardians shall be notified of each occurrence of restraint and seclusion with a time frame not to exceed 24 hours." 4. "The nurse will initiate a debriefing following each episode of restraint and seclusion no longer than 24 hours after the episode in order to review the event and plan any future, earlier alternative interventions. The staff member will document in the patient's record that the parent or guardian has been notified." 5. "Facility staff must document all incidents of restraint/seclusion on the Seclusion and Restraint Reporting form." 6. "The leadership staff shall maintain a performance improvement program designed to continuously review monitor and analyze the use of seclusion and restraint interventions." 7. "A formal Interdisciplinary Treatment Team Review will be held for all patients placed in seclusion or restraints. This shall be documented in the medical record." 8. "The facility Clinical Program Manager II is responsible for assuring that on-going documentation and monitoring of patients placed in seclusion and or restraints is maintained." On 8/24/09 at 2:00 PM, an interview was conducted with Employee #2 who acknowledged the findings regarding the investigation into the physical abuse incident failed to reveal documented evidence the physician wrote an	S 320		

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S 320	Continued From page 15 order for a physical restraint or CPART hold on the date of the incident on 06/15/09. There was no documented evidence the use of a physical restraint on Patient #1 was reported to the charge nurse. There was no documented evidence a facility restraint incident report was completed following the use of a restraint on 6/15/09. There was no documented evidence a Patient Denial of Rights was completed following the incident. The facility failed to follow policy and procedure by not notifying law enforcement or conducting a complete investigation into the physical abuse incident by not interviewing patient witnesses. The facility failed to follow policy and procedure by not placing the employees involved in the abuse allegation on administrative leave pending completion of the investigation. A review of the facility CPART training records revealed both employees CPART certification was valid until 6/12/10. A review of the facilities CPART training manual last revised 01/05 failed to reveal documented CPART restraint holds that involved twisting a patients arm behind the back and restraining a patient against a wall. A review of Patient #1's medical record and staffing schedules revealed Employee #7 and Employee #8 continued to have frequent contact with the patient and be involved in the care and treatment of the patient following the physical abuse restraint incident on 06/15/09 and until the patient's discharge from the facility on 7/23/09. The Facilities Report and Investigation of Abuse and or Neglect of Patients Policy and Procedure last revised 12/07 included the following:	S 320		

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S 320	Continued From page 16 1. Policy: "Physical abuse and/or neglect of patients is unlawful and will not be condoned or allowed in any Division program. Suspected abuse or neglect is to be immediately reported to the supervisor and Clinical Program Manager II." "Abuse and neglect means the non-accidental physical or mental injury, sexual abuse, negligent treatment or maltreatment of an individual under circumstances which indicate that the individual's health or welfare is harmed or threatened thereby." 2. Procedure: The Clinical Program Manager II, or person acting in that capacity upon receiving a report of alleged abuse or neglect will take the following actions: a. "As soon as possible, but within 24 hours of being apprised of suspected abuse or neglect, notify the law enforcement agency with jurisdiction over the incident." b. "Immediately, but in no case longer than 24 hours, notify the Deputy Administrator, Division of Child and Family Services, or the person acting in that capacity, of the incident." c. "As soon as possible, but within 24 hours, notify the patient legal guardian, if one has been appointed of the incident. Notify Child Protective Services." d. "As soon as practical, separately interview witnesses, the alleged victim, and the alleged perpetrator for the purpose of ascertaining the need for immediate action to prevent further abuse or neglect." e. "If the Clinical Program Manager II initially finds physical evidence and /or corroboration witnesses of the reported abuse and neglect, he/she shall notify the appropriate law enforcement agency." f. "If upon preliminary investigation, the Clinical	S 320		

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S 320	Continued From page 17 Program Manager II determines the facts surrounding the alleged incident provide reason to believe that the patient is in danger of continued or repeated abuse or neglect, immediate action shall be taken which may include: 1. "Placing the alleged perpetrator on administrative leave." 2. "Transferring the patient or staff to another program within the agency to ensure the patient's proper care and protection." Complaint #NV00022688 Surveyor: 27469 Patient #9 Patient #9 was re-admitted to the facility on 7/1/09 with diagnoses including mood disorder, conduct disorder, alcohol abuse, marijuana abuse, history of asthma and severe constipation. On 7/28/09, an allegation was made by Patient #9 of a staff member poking her in the chest. The Las Vegas police unsubstantiated the allegation of physical and sexual abuse. The facility failed perform an internal investigation per their Reporting and Investigation of Abuse and/or Neglect of Patients. Complaint #NV00022683 Surveyor: 21994 Patient #8 Patient #8, a 12 year old male, was admitted on 8/7/09, with a diagnosis of mood disorder. The facility failed to have evidence of an investigation of the implementation of a CPART hold on 8/13/09, after the DON documented "Charge RN	S 320		

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S 320	Continued From page 18 was informed this CPART may have been unnecessary when the child only postured, no actual assault." A day later the patient complained of pain in the right shoulder blade. Severity: 3 Scope: 1	S 320		
S 325 SS=I	NAC 449.3628 Physical Restraint Use 5. The governing body shall ensure that the use of any physical restraints on a patient is initiated only pursuant to a physician's order or protocols approved by the medical staff and the hospital administration. This Regulation is not met as evidenced by: Surveyor: 21994 Based on interview, record review and document review the facility failed to ensure the use of physical restraints on patients was initiated pursuant to physician's order and facility policy (Restraint/Seclusion of Patients policy #8.03 dated 1/1/2005 and reviewed on 7/2006, Reporting of Denial of Rights #2.02 effective 1/1/2005 and revised on 12/2007, and Report and Investigation of Abuse and or Neglect of Patients last revised 12/07) for 6 of 11 patients (Patients #1, #5, #6, #7, #8, #9). Interviews throughout the survey with the mental health technicians and review of the CPART (Conflict Prevention Response Training) training manual revealed staff were to utilize the least restrictive measures. The DON reported that, after a CPART hold, the RN does a "pain assessment." She reported they do not document all items as identified in the Restraint/Seclusion of Patients policy.	S 325		

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S 325	Continued From page 19 Patient #7 Patient #7, a 15 year old male, was admitted on 7/10/09, with the diagnoses that included depressive disorder, history of psychotic disorder, history of impulse disorder, and history of oppositional defiant disorder. On 7/11/09 at 11:27 AM, a physician's order read "physical restraint up to 2 hours for physical aggression..." The facility failed to have evidence of an Incident/Accident report, assessment, nor Denial of Rights (DOR) for this incident. On 7/24/09 at 5:45 PM, an incident report documented a "10 minute CPART hold." The facility failed to have evidence of a DOR for this incident or a physician's order for the hold. On 7/26/09 at 11:00 AM, an incident report documented a "2 minute CPART hold." The facility did not produce a DOR for this incident or a physician's order for the CPART hold. On 7/27/09 at 11:40 AM, a physician's order for a "therapeutic hold" was documented. The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. On 7/27/09 at 4:30 PM, a physician's order for "CPART hold for at least 30 minutes to keep safe" was documented. The RN notes documented the CPART hold occurred. The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. On 8/9/09 8:05 PM, an incident report documented a "CPART hold..." The facility did not produce a DOR for this incident.	S 325		

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S 325	Continued From page 20 Patient #8 Patient #8, a 12 year old male, was admitted on 8/7/09, with a diagnosis of mood disorder. A mental health technician (MHT) progress note written on 8/13/09, read "I will show you and postured at the nurse!! To hit him and was place in CPART hold for 7 minutes." An RN progress note written on 8/13/09 read "He refused to go to Quiet Room, then he postured to hit staff with a closed fist. CPART hold was implemented. Dr. was made aware of the incident..." A physician's order dated 8/13/09 at 4:45 PM read "CPART hold for physical aggression..." The Incident report documented "Action Taken: CPART hold.... On initial assessment the patient denied pain. A day later the patient claimed of pain in the right shoulder blade. No swelling nor limitation of movement on the involved extremity. He was given Ibuprofen for pain." The DON wrote in the comment section "Charge RN was informed this CPART may have been unnecessary when the child only postured, no actual assault." The debriefing was completed. Documentation indicated the "child could have controlled his anger." There was no documented evidence of a discussion of the possibility of an unnecessary CPART and what the staff could have done differently. There was no "Denial of Rights" completed for the CPART hold. Patient #5 Patient #5, a 16 year old female, had a current admit date on 6/24/09 and a previous admission on 5/7/09. Her diagnoses included bipolar	S 325		

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S 325	Continued From page 21 disorder, mixed, severe psychosis, eating disorder, and post traumatic stress disorder. On 5/11/09 at 11:28 AM, an incident documented that a "Therapeutic Hold" was done between 11:28 AM and 11:32 AM. On 5/20/09 at 7:00 PM an incident was recorded as a "5 min CPART hold." The facility failed to have evidence of a physician's order for the CPART hold. On 7/30/09 at 4:00 PM an incident was recorded as a "5 min CPART hold." The facility failed to have evidence of a physician's order for the CPART hold. Patient #6 Patient #6, a 15 year old male, was admitted on 2/2/09, with the diagnosis of psychotic disorder. On 7/13/09 at 3:55 AM a physician's order read "Place in locked seclusion for up to 1 hour for safety." An incident was recorded on 7/13/09 at 3:25 AM and read "was in seclusion for 30 minutes." A daily 15 minute "Unit Where About Sheet" was presented by the facility as a "Restraint Monitoring" sheet. The Quality Assurance Specialist (QA) reported the "Unit Where About Sheet" was used when monitoring the "Seclusion" room. The form was blocked into in 15 minute increments. The QA reported the staff document "QR" when a patient was in seclusion. She indicated "QR" stood for Quiet Room. She stated the staff also use "QR" when the patient is in the quiet room when the door is unlocked.	S 325		

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S 325	Continued From page 22 Review of the the 7/13/09, "Unit Where About Sheet" revealed Patient #6 was in the "QR" from 3:45 AM to 5:15 AM. The 7/13/09 "Unit Where About Sheet" indicated the patient was listed as "QR" in the 8:00 PM section and "QR" in the 8:45 PM to 10:45 PM time sections. The facility failed to have documented evidence "continuous in-person monitoring" occurred for Patient #6. On 7/13/09 at 8:30 PM, an incident was recorded as a "3 person CPART hold..." and on 7/31/09 at 8:10 PM an incident indicated a "CPART hold." The facility did not have evidence of a physician's order for the CPART holds. Surveyor: 26855 Patient #1 Patient #1 was a 13 year old white juvenile admitted to the facility on 02/03/09 with a diagnosis that included bipolar disorder, oppositional defiant disorder and impulse control disorder. The patient was discharged from the facility on 07/23/09. A Physicians Discharge Summary dated 07/23/09 indicated the patient struggled throughout the time in the residential program. On admission the patient was extremely oppositional and labile. Several outbursts required physical holds including the day of admission. A Residential Treatment Center Services Continued Stay Request Note dated 04/15/09 and 06/15/09 indicated the patient was physically restrained for aggressive and violent behaviors on the following dates: 1. 02/03/09 - Physical restraint for aggressive	S 325		

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S 325	Continued From page 23 violent behaviors. 2. 02/09/09 - Physical restraint for violent behaviors and attempting to harm staff. 3. 04/13/09 - Physical restraint for aggressive behaviors and attempting to harm staff. 4. 06/15/09 - Physical restraint for aggressive behavior towards a peer. 5. A Nursing progress Note dated 6/17/09 at 1:07 PM, indicated the patient was placed in a physical restraint for being verbally and physically aggressive. A review of Physician Orders from the date of admission on 2/3/09 to the date of discharge on 7/23/09 revealed one documented physician order for physical restraint for aggressive and violent behavior on 2/3/09. There were no other documented physician orders for restraint use. On 8/24/09 at 4:00 PM, Employee #2 acknowledged there was no documented physician's orders in the medical record for physical restraint use on the patient for 2/9/09, 4/13/09, 6/15/09 and 6/17/09 per facility policy. Employee #2 acknowledged there was no Restraint Incident Reports or Denial of Rights Forms for physical restraint use on Patient #1 for 2/9/09, 4/13/09, 6/15/09 and 6/17/09 per facility policy. The facility Restraint Seclusion Policy last revised 07/06 indicated restraint and seclusion shall only be used in an emergency safety measure in situations of imminent danger to patients, staff or others when less restrictive measures have been or likely to be ineffective in averting danger.	S 325		

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S 325	Continued From page 24 Surveyor: 27469 Patient #9 Patient #9 was initially admitted on 2/27/09 with the diagnoses that included depressive disorder, post traumatic stress disorder, significant allergies, history of seizures, and history of asthma. Patient #9 was re-admitted to the facility on 7/1/09 with diagnoses including mood disorder, conduct disorder, alcohol abuse, marijuana abuse, history of asthma, and severe constipation. On 8/7/09 at 4:55 PM, a physician's order was received to "Place patient in seclusion for homicidality toward peers." The facility did not produce a DOR or an assessment of the patient for this incident. The facility did not produce documentation of seclusion monitoring. At 6:55 PM, a physician's order was received to "continue seclusion for secondary for safety of patients and staff." Review of an incident report dated 8/7/09, revealed that Patient #9 was placed in locked seclusion from 5:00 PM until 9:00 PM for threatening to kill a peer. There was no documentation of how the staff "escorted" Patient #9 to seclusion. There was no documented evidence of VS completed after two hours, a restraint seclusion form for the CPART, or DOR for chemical restraint for the medication given at 6:15 PM. The client notes documented Patient #9 was told to stop hitting the quiet room door at 6:00 PM or she would get a shot. On 8/7/09 at 6:15 PM, a physician's order was received for "Ativan 4 mg IM now for aggression." There was no documented evidence a complete physical assessment was completed after the restraint	S 325		

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S 325	Continued From page 25 was implemented. Patient #9 did not participate in the debriefing. The documentation for actions that may be useful for future prevention included "no suggestions at this time except discharge from unit." Complaint #NV00022688 Severity: 3 Scope: 3	S 325		
S 328 SS=E	NAC 449.3628 Physical Restraint Use 6. If the use of physical restraints is permitted pursuant to approved protocols, the approved protocols must include: (c) A provision for notifying the physician within 12 hours after the use of the physical restraints is initiated This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and document review the facility failed to consistently follow the facility restraint policy and procedure and notify a physician within 12 hours after the use of a physical restraint for 5 of 11 patients. (Patients #1, #5, #6, #7, and #8) Complaint #NV00022688 Severity: 2 Scope: 2	S 328		
S 329 SS=E	NAC 449.3628 Physical Restraint Use 6. If the use of physical restraints is permitted pursuant to approved protocols, the approved protocols must include: (d) A requirement that a verbal or written order of	S 329		

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S 329	Continued From page 26 the physician be obtained and entered into the medical record of the patient This Regulation is not met as evidenced by: Surveyor: 21994 Based on document review and record review the facility nursing staff failed to consistently obtain verbal or written physician orders for all instances of restraint use and document the orders in the patients medical records for 5 of 11 patients. (Patients #1, #5, #6, #7, #9) Complaint #NV00022688 Severity 2 Scope 2	S 329		
S 332 SS=F	NAC 449.3628 Physical Restraint Use 8. The hospital shall have a process for quality improvement to identify appropriate opportunities for reducing the use of physical restraints. The process for quality improvement must include areas for measurement and assessment to identify opportunities to reduce the risks associated with the use of physical restraints through the introduction of preventive strategies, innovative alternatives to the use of physical restraints and improvements to the process of using physical restraints. This Regulation is not met as evidenced by: Surveyor: 21994 Based on interview, document review and chart review the facility failed to ensure an effective process through quality assurance for reducing the use restraints through the introduction of preventative strategies and the provision on innovative alternatives and failed to have a plan to reduce the number of physical and chemical	S 332		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 332	Continued From page 27 restraints. Severity: 2 Scope: 3	S 332		
S 602 SS=I	NAC 449.394 Psychiatric Services 3. A hospital shall develop and carry out policies and procedures for the provision of psychiatric treatment and behavioral management services that are consistent with NRS 449.765 to 449.786, inclusive, to ensure that the treatment and services are safely and appropriately used. The hospital shall ensure that the policies and procedures protect the safety and rights of the patient. This Regulation is not met as evidenced by: Surveyor: 27469 Based on staff interview and record review, the facility failed to monitor and assess the administration of a chemical restraint and failed to complete a Denial of Rights in accordance with facility policy Restraint/Seclusion of Patients policy #8.03 dated 1/1/2005 and reviewed on 7/2006 for 5 of 11 patients. (Patients #5, #6, #7, #8, and #9) Patient #9 Patient #9 was initially admitted on 2/27/09 with the diagnoses that included depressive disorder, post traumatic stress disorder, significant allergies, history of seizures, and history of asthma. Patient #9 was re-admitted to the facility on 7/1/09 with diagnoses including mood disorder, conduct disorder, alcohol abuse, marijuana abuse, history of asthma, and severe constipation.	S 602		

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	NVS2128HOS	A. BUILDING _____ B. WING _____	08/27/2009

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S 602	Continued From page 28 On 7/13/09 at 5:35 PM, a physician's order was received for "Ativan 2 mg IM STAT for increase anxiety per patient request." The facility did not produce a DOR for a chemical restraint or an assessment of Patient #9 for this incident. On 7/13/09 at 6:30 PM, a physician's order was received for "Benadryl 50 mg IM now for increase anxiety. And may give another dose of Ativan 2 mg IM if patient still anxious/agitated." The facility failed to produce a DOR for a chemical restraint or an assessment of the patient for this incident. On 7/13/09 at 9:30 PM, a physician's order was received for "Ativan 2 mg by mouth x 1 dose due to patient refused to take the Seroquel 100 mg." The facility failed to produce a DOR for a chemical restraint or an assessment of the patient for this incident. On 7/14/09 at 9:15 AM, a physician's order was received for "Ativan 2 mg IM x 1, Benadryl 50 mg IM x 1 for aggressive behavior, therapeutic restraint x 30 minutes or till patient calms down." The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident. On 7/14/09 at 10:00 AM, a physician's order was received for "Ativan 5 mg IM x 1 severe aggression, patient kept in locked seclusion due to severe aggression for safety issue." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident. On 7/14/09 at 8:00 PM, a physician's order was received for "Haldol 5 mg IM STAT and Benadryl 50 mg IM STAT for increase anxiety." The 15 minute monitor log (DWTC Form #33)	S 602		

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S 602	Continued From page 29 documented 22 oppositional behavior episodes from 7:00 AM to 2:45 PM and 12 episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident. On 7/20/09 at 8:00 PM, a physician's order was received for "Haldol 5 mg IM STAT and Benadryl 50 mg IM STAT due to severe anxiety/agitation/threatening to hurt others." The 15 minute monitor log documented 12 physical and verbal abuse, non-compliant behaviors from 7:00 AM to 2:45 PM and 12 episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident. On 7/21/09 at 2:10 PM, a physicians order was received for "Benadryl 50 mg IM, Haldol 5 mg IM STAT x 1 for severe aggressive behavior towards staff." The 15 minute monitor log documented nine oppositional behavior episodes from 7:00 AM to 2:45 PM and three episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident. On 7/24/09 at 5:46 PM, a physician's order was received for "CPART for patient and staff safety, IM Haldol 5 mg/Benadryl 50 mg IM now." The 15 minute monitor log documented seven oppositional behavior episodes from 3:00 AM to 10:45 PM and four episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident.	S 602		

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S 602	Continued From page 30 On 7/26/09 at 9:30 PM, a physician's order was received for "Ativan 5 mg IM or PO, CPART for patient and staff safety." The 15 minute monitor log documented two oppositional behavior episodes from 3:00 AM to 10:45 PM and six episodes of aggressive behavior documented for same time period. The facility did not produce a DOR for a chemical restraint. On 7/27/09 at 5:30 PM, a physician's order was received for "Ativan 4 mg IM and Haldol 5 mg IM now agitation." The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident. On 7/30/09 at 11:40 PM, a physician's order was received for "Ativan 4 mg IM and Haldol 5 mg IM STAT, agitation." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident. On 8/1/09 at 7:10 PM, a physician's order was received for "Ativan 4 mg IM STAT and Haldol 5 mg IM STAT due to aggressive behaviors and increase agitation." The incident report for 8/7/09 at 1:00 PM documented patient to patient physical aggression. The action taken documented Patient #9 was escorted to the quiet room. There was no documented evidence of a DOR being completed or a that debriefing had occurred. There was no documented evidence a complete physical assessment completed after the restraint was implemented. There was no documentation of how the patient was escorted to the quiet room. The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident. On 8/7/09 at 4:55 PM, a physician's order was	S 602		

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S 602	Continued From page 31 received to "Locked seclusion secondary to homicidal threats, Ativan 2 mg po x 1 acute hostility/posturing." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident. On 8/11/09 at 6:00 PM, a physician's order was received for "Thorazine 50 mg IM STAT for increase anxiety and per patient request." The facility did not produce a DOR for a chemical restraint or an assessment of the patient for this incident. On 8/15 at 7:30 PM, a physician's order was received for "Thorazine 50 mg x 1 now." The facility did not produce a DOR for chemical restraint or an assessment of the patient for this incident. There was no documented route for the medication found on the physician's order. Complaint #NV00022688 Surveyor: 21994 Patient #7 Patient #7, a 15 year old male, was admitted on 7/10/09, with the diagnoses that included depressive disorder, history of psychotic disorder, history of impulse disorder, and history of oppositional defiant disorder. On 7/10/09 at 12:30 PM, a physician's order was received for "Haldol 5 mg IM STAT, Ativan 2 mg IM STAT, Benadryl 50 mg IM STAT for severe anxiety and aggressive behavior." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. The IM medications were documented on the MAR as given; nothing was documented on the back of the MAR in the "Reasons and Results" section.	S 602		

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S 602	Continued From page 32 On 7/11/09 at 11:27 AM, a physician's order stated "physical restraint up to 2 hours for physical aggression, Haldol 5 mg IM and Benadryl 50 mg IM STAT." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. On 7/21/09 at 12:30 PM a physician's order was received for "Haldol 5 mg IM STAT, Ativan 2 mg IM STAT, Benadryl 50 mg IM STAT." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. The medications were documented on the MAR as given. However, nothing was documented on the back of the MAR in the "Reasons and Results" section. On 8/9/09 8:05 PM, an incident report documented a "CPART hold, Haldol 5 mg IM, Benadryl 50 mg IM" to be given. The facility did not produce a DOR for this incident. Patient #8 Patient #8, a 12 year old male, was admitted on 8/7/09, with a diagnosis of mood disorder. A registered nurse progress note dated 8/11/09, read "Escorted to hallway down to quiet room and was making negative remarks to staff in an intimidating fashion. Given Benadryl IM at 9:15 AM which he initially refused but with firm redirection cooperated with procedure." The facility did not produce an Incident/Accident report, Assessment, nor DOR for this incident. A physician's order dated 8/11/09 at 9:14 AM read "Benadryl 25 mg IM STAT for severe anxiety." The MAR provided indicated the	S 602		

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S 602	Continued From page 33 Benadryl was given, however there was no "Reason and Results" recorded for the medication. An RN progress note written on 8/13/09 read "He refused to go to Quiet Room, then he postured to hit staff with a closed fist. CPART hold was implemented. Dr. was made aware of the incident. Benadryl 25 mg IM was ordered and was given at 4:50 PM." A physician's order dated 8/13/09 at 4:45 PM read "CPART ..., Benadryl 25 mg IM Now." The MAR indicated the Benadryl was given, there was no "Reason and Results" recorded for the medication. There was no "Denial of Rights" completed for the Benadryl IM. The record did not contain a consent form for the use of the Benadryl. Patient #5 Patient #5, a 16 year old female, had a current admit date on 6/24/09 and a previous admission on 5/7/09. Her diagnoses included bipolar disorder, mixed, severe psychosis, eating disorder, and post traumatic stress disorder. Patient #5 was prescribed and given Benadryl 50 mg by mouth as needed for anxiety on 7/6/09 at 5:00 PM; 7/12/09 at 4:30 PM; 7/13/09 at 8:00 PM; 7/14/09 at 8:00 PM; 7/26/09 at 5:30 PM; and 7/30/09 at 4:45 PM. The "Reasons and Results" for the medications were not documented on the back of the MAR. On 5/10/09 at 4:55 PM an incident was documented that "staff held her from 3:55 to 4:55." The description of occurrence section of the report read "at start of shift IM meds to include Ativan, Benadryl and Zyprexa after refused to take PO. Needed PRN meds as she	S 602		

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S 602	Continued From page 34 was hitting, kicking ..." On the physician order for 5/10/09, the RN documented "5/10/09 11:45 PM error noted 5/10/09 3:50 PM Benadryl 50 mg and Ativan 1 mg IM STAT." The MAR indicated the Benadryl and Ativan were given at 3:40 PM. No "Reasons and Results" were recorded on the back of the MAR. The July 2009 MAR indicated Benadryl 50 mg PO (orally) PRN was given on six occasions. The "Reason and Results" section of the MAR provided was blank. Patient #6 Patient #6, a 15 year old male, was admitted on 2/2/09, with the diagnosis of psychotic disorder. On 7/3/09 at 9:00 PM an incident was recorded as "CPART hold and Benadryl 50 mg IM STAT. A physician's order on 7/3/09 at 9:00 PM read"..., Benadryl 50 mg IM STAT." The MAR did not indicate the Benadryl 50 mg IM STAT was given on 7/3/09 at 9:00 PM. On 7/11/09 at 10:15 AM a physician's order was written for "Benadryl 50 mg IM STAT, Haldol 5 mg IM STAT for severe anxiety and physical aggression." The facility did not produce an Incident/Accident report, assessment, nor DOR for this incident. The MAR provided indicated the medications were given. There were no "Reasons and Results" documented on the MAR for the medications. On 7/13/09 at 8:30 PM, an incident was recorded as a "... Benadryl 50 mg, Ativan 2 mg, Haldol 5 mg IM given." There was no physician's order for	S 602		

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S 602	Continued From page 35 the Benadryl 50 mg, Ativan 2 mg, or Haldol 5 mg IM. The MAR provided indicated Benadryl 50 mg, Ativan 2 mg, and Haldol 5 mg IM were given at 8:00 PM. On 7/18/09 at 11:55 AM, a physician's order read "CPART hold for physical/violent aggression. Benadryl 50 mg IM STAT, Ativan 2 mg IM STAT, and Haldol 5 mg IM STAT. The Benadryl, Ativan, and Haldol were not on the MAR provided. Interviews with the Director of Nursing (DON) revealed when a IM PRN medication was given the nurses (RN) were to record the "Reasons and Results" on the back of the MAR. An interview on 8/25/09 at 2:45 PM with a unit RN revealed the nurses did not always document the "reasons and results" of PRN medication on the MAR. An interview on 8/26/09 at 10:30 AM with another RN revealed he would complete the "reasons and results" on the MAR if the medication was an antipsychotic or an intramuscular administration. Severity: 3 Scope: 3	S 602		